WINCHESTER HOSPITAL

Winchester, Massachusetts

*Please fill out at home

ENDOSCOPY MEDICATION RECONCILIATION LIST

Allergies:			Date		Time		
Name of Pharmacy (inc	ludir	ng address and phone #):					
Information Obtained:		atient □ Family □ Providist/Bottles □ Other:					
Home Medications:		all medications including pres herbal supplements. one	cription, over	the counter m	edications, v	itamins,	
Medication Name		Direction (Dose, Route, Frequency)	Indication (Reason)	Last Dose (Date/Time)		/ Changes	
						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Pre-procedure Nurse Sign	nature	e documenting medication list		n	ate	Time	
		e documenting last dose:			ate		
Comme	ents .	/ Changes N	ew Medicatio	n Instruction	S		
Discharge Medication Rev						Time	
nave reviewed nome medication nless specifically indicated in the pplicable specialist.)	comme	ers previously written. This does not cons ent /changes. Any questions about chang	utute an order. It is ges should be discu	not my intent to at	ent's primary care	physician or	
Post-Procedure RN					ate:	Time	
		reviewed with me and copy gi	ven to patient/	sponsor.			
Patient/Sponsor Signature				Date:			

WH1254 (Rev 06/13)